DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU AT GARDNERVILLE, AL & MC	**1565 VIRGINIA RANCH ROAD, GARDNERVILLE, NEVADA ,89410-5704**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of State Licensure annual grading survey conducted at your facility from 12/08/22 to January 4, 2023. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for a total of 150 Residential Facility for Group beds: 126 beds for elderly and disabled persons and/or assisted living services, Category II residents and 24 beds for persons with Alzheimer's disease, Category II Alzheimer's residents. The census at the time of the survey was 104. Twenty-five resident files were reviewed, and ten employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. There was one complaint investigated. Complaint #NV00067667 Complaint #NV00067667 with the allegation the facility did not have authority to keep a resident in the facility and prevented the resident from being discharged could not be substantiated due to resident preference at the time of the investigation. The investigation into the allegations included: Observations of residents in the memory care unit and of the resident of concern in the resident's room. Interviews were conducted with the resident	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: KATIE NICHOLS Title: Administrator Date: 01/24/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	of concern and the Executive Director. Reviewed five resident records including the resident of concern, to include admission agreement, health and physical reports, activities of daily living assessments, emergency contact, and Physician Determination Statement. Reviewed the facility polices including Admission Policy dated 10/2018, and the Abuse, Neglect and Exploitation Policy dated 10/2018. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			
0053 SS= D	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on record review, document review and interview, the Administrator failed to ensure tuberculosis (TB) testing records were complete, including the time given and/or time results read, for 3 of 25 sampled residents (Resident #9, #20 and #24). Findings include: Resident #9 Resident #9 was admitted to the facility on 10/27/21 with diagnoses including hypertension, end stage renal disease, type II diabetes mellitus, hypothyroidism, and back pain. Resident #9's clinical record documented an annual TB test given on 10/27/22 and read negative on 10/29/22. Resident #9's TB testing lacked evidence of the time given and the time read. Resident #20 Resident #20 was admitted to the facility on 04/19/22 with diagnoses including atrial fibrillation, sleep apnea, hyperthyroidism, and type II diabetes mellitus with diabetic neuropathy. Resident #20's clinical record documented	0053	1. Signs and Symptom documentation completed for residents #9, #20 and #24. 2-step TB tests started 1/20/2023 for all three residents, documentation to include time of administration. 2. Health and Wellness Director or designee will document date and time all TB tests are administered and results read to ensure 48-72 hr window. 3. Executive Director, Health and Wellness Director or designee will verify all initial and annual TB test documentation includes times of administration/results read. If resident arrives with incomplete documentation from another facility, HWD or designee will administer/read new TB test. 4. Health and Wellness Director 5. 1/30/2023 6.Attachment	01/30/2023

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	an admission first-step TB test given on 04/19/22 and read negative on 04/21/22 and a second-step TB test given on 04/26/22 and read negative on 04/28/22. Resident #20's TB testing lacked evidence of the times given and the times read. Resident #24 Resident #24 was admitted to the facility on 08/10/18 with diagnoses including atrial fibrillation, hyperlipidemia, and low back pain. Resident #24's clinical record documented an annual two step TB test with the first step given on 07/01/22 and read negative on 07/03/22 and a second-step TB test given on 07/05/22 and read negative on 07/07/22. Resident #24's TB testing lacked evidence of the times given and the times read. On 12/08/22 at 3:46 PM, the Administrator confirmed the TB records for Residents #9, #20 and #24 lacked the times given and the times read and the standard of practice of reading the TB test between 48 and 72 hours could not be documented without times. Severity: 2 Scope: 1			
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home,	0074	1. Employee #5 hire date is 05/27/2021; initial elder abuse training completed 05/27/2021. Employee #5 annual elder abuse training completed 05/12/2022. 2. Business Office Director, Executive Director or designee will audit employee files monthly to ensure Elder Abuse annual training is completed prior to the previous year's expiration date. 3. Business Office Director, Executive Director or designee will audit employee files monthly for compliance. 4. Business Office Director, Executive Director 5. 05/12/2022 6. Attachment	05/12/2022

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	facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care			

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	services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on record review and interview, the facility failed to ensure employees completed timely annual elder abuse prevention training for 1 of 10 sampled employees (Employee #5). Findings include: Employee #5 Employee #5 was hired as a Medication Technician/Caregiver on 05/27/21. The employee's personnel file documented			

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	initial elder abuse training completed on 02/02/21, and annual abuse training completed on 05/12/22, three months late. On 12/08/22 at 11:18 AM, the Business Office Manager (BOM) verbalized Employee #5 did not have elder abuse prevention training completed timely for 2022 and confirmed the elder abuse prevention training was three months late. Severity: 2 Scope: 1			
0178 SS= D	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the air returns in the kitchen were free from an accumulation of dust. Findings include: On 12/08/22 at 9:05 AM, the return air filter in the main kitchen area and dry storage area had a heavy accumulation of dust. The air filter on the ice machine in the kitchen had a heavy accumulation of dust. On 12/08/22 at 9:11 AM, the Dining Director confirmed the return air filters and the ice machine air filter had a heavy accumulation of dust and needed to be cleaned. The Dining Director verbalized not knowing the last time the filters were cleaned or what the cleaning schedule was. Severity: 2 Scope: 1	0178	1) The return air filters in the main kitchen area and dry storage area were replaced. The air filter on the ice machine was replaced. 2) Dining Services Director, Maintenance Director or designee will clean or replace filters when required. 3) Dining Services Director or Maintenance Director will visually inspect filters for cleanliness weekly. 4) Executive Director 5) 12/9/2022 6) Attachment	12/09/2022

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0430	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation and interview, the facility failed to ensure all evacuation maps were present on the third floor of the facility. On 12/08/22 at 11:02 AM, the Administrator confirmed the evacuation maps were not replaced on the third floor and no temporary evacuation maps were in place as a result of their new signage program in the building. State Fire Marshal Referral	0430	1) Evacuation plans were posted on 3rd floor 12/9/2022 2) Executive Director, Maintenance Director or designee will verify evacuation plans are in place at all times and replaced if removed for any reason. 3)Executive Director, Maintenance Director or designee will verify evacuation plans are in place at all times. 4) Executive Director or designee 5) 12/9/2022 6) Attachment	12/09/2022
0874 SS= E	Medication Administration-Report Received - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist or registered nurse at least once every six months, was initialed by the Administrator	0874	1)Administrator signed most recent pharmacy review, completed on 12/2/2022 at time of survey on 12/8/2022. 2) Community will continue to have pharmacy review medications at least every 6 months for all residents who are on community medication management program. Executive Director will review and sign pharmacy reviews/report within 72 hours of receipt. Wellness Director or designee send recommendations to residents' physicians within 72 hours of receipt of recommendations. 3) Executive Director will review and sign pharmacy reviews within 72 hours or report.	12/08/2022

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	for 9 of 25 residents residing in the facility for longer than six months (Resident #2, #6, #7, #1, #13, #15, #19, #17, and #20). Findings include: Resident #2 Resident #2 was admitted to the facility on 07/23/21, with diagnoses including dementia, chronic kidney disease, and hypertension. Resident #2's file contained a medication reviews dated 09/27/22 and 12/02/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #6 Resident #6 was admitted to the facility on 04/08/21, with diagnoses including osteoporosis and hypertension. Resident #6's file contained a medication review dated 09/27/22 and 12/02/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #7 Resident #7 was admitted to the facility on 04/02/19, with diagnoses including memory concerns, osteoporosis and irritable bowel syndrome. Resident #7's file contained a medication reviews dated 09/27/22 and 12/02/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #1 Resident #1 was admitted to the facility on 06/27/22, with diagnoses including hypertension, dyslipidemia, and dementia. Resident #1's file contained a medication review dated 12/02/22, however, the medication review lacked documented evidence of the Administrator's or the Designee's signature indicating a review of the reports. Resident #13 Resident #13 was admitted to the facility on 12/13/21, with diagnoses including congestive heart failure, and hypertension. Resident #13's file contained a medication review dated 12/02/22, and 06/24/22 however, the medication review lacked documented evidence of the Administrator's or the Designee's signature indicating a review of the reports. Resident		Executive Director will verify Health and Wellness Director or designee send recommendations to residents' physicians within 72 hours or receipt of recommendations. 4) Executive Director 5) 12/8/2022 6) Attachment	

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	#15 Resident #15 was admitted to the facility on 04/06/21, with diagnoses including vascular dementia, hypertension, and anxiety. Resident #15's file contained medication reviews dated 12/02/21 and 03/30/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #19 Resident #19 was admitted to the facility on 10/14/20, with diagnoses including dementia, hypertension, hyperlipidemia, and hypothyroidism. Resident #19's file contained medication reviews dated 03/30/22 and 06/04/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #17 Resident #17 was admitted to the facility on 05/09/19, with a diagnosis of dementia. Resident #17's medication review reports dated 09/30/22 and 03/30/22, lacked documented evidence the Administrator or the Designee had reviewed the reports. Resident #20 Resident #20 was admitted to the facility on 04/19/22 with diagnoses including atrial fibrillation, sleep apnea, hyperthyroidism, and type II diabetes mellitus with diabetic neuropathy. Resident #20's file contained medication reviews dated 09/27/22 and 12/02/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. On 12/08/22 at 12:10 PM, the Executive Director confirmed the medication profile reviews lacked the Administrator's or Designee's signature to indicate the reports were reviewed and verbalized the review should take place within 72 hours of receipt of the report. The facility policy titled "Medication Policies and Procedures," dated October 2018, documented the facility would conduct medication drug regimen reviews for accuracy and appropriateness at least every six months and the reviews would be initialed by the			

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	Executive Director. Severity: 2 Scope: 2			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on clinical	0878	1)Resident #15- Donepezil HCL 10 mg received and placed in cart 12/8/2022; Acetaminophen 500 mg in overstock at time of inspection, placed in cart 12/9/2022. Resident #17-Vitamin B12 received and placed in cart 12/8/2022;Carbamide peroxide solution 6.5% received 1/24/2023 and placed in cart. Resident #18 Pravastatin sodium 20 mg order discontinued 11/27/2022. Resident #10-Acetaminophen325mg and Bisacodyl 5m received 12/22/22, placed in cart. Resident #22-Ondansetron 4mg order has been corrected in eMAR system to match physician order and medication label to read take one tablet by mouth every six hours, change of directions sticker added to medication at time of inspection. Resident #12- Latanoprost solution 0.005% was located in refrigerator at time of inspection, dispensed by pharmacy on 12/5/2022. Resident #21- Acetaminophen 500mg received 12/15/2022,placed in cart. 2) Health and Wellness Director or designee will verify medications on MAR are in med cart daily for administration and that orders in MAR match medication on hand, if there is a discrepancy physician will be contacted for clarification. HWD or designee will order medications prior to current supply running out. 3) Health and Wellness Director or designee will review medication carts daily during med passes to ensure compliance. 4) Executive Director, Health and Wellness Director 5) 01/24/2022 6) Attachment	01/24/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record review and interview, the facility failed to ensure medications were on-site to administer as prescribed for 7 of 25 sampled residents (Resident #15, #17, #18,#10, #12, #21 and #22). Findings include: Resident #15 Resident #15 was admitted to the facility on 04/06/21, with diagnoses including vascular dementia, hypertension, and anxiety. Resident #15's December 2022 Medication Administration Record (MAR) documented donepezil HCL tablet 10 milligrams (mg), give one tablet by mouth at bedtime. The medication was not available on site. Resident #15's December 2022 MAR documented acetaminophen tablet, 500 mg, give one tablet by mouth every eight hours as needed for pain. The medication was not available on site. On 12/08/22 at 4:29 PM, the Administrator confirmed the facility lacked Resident #15's donepezil and acetaminophen. Resident #17 Resident #17 was admitted to the facility on 05/09/19, with a diagnosis of dementia. A physician's order dated 05/10/19, documented Vitamin B-12 tablet, one tablet by mouth, one time a day. The medication was not available onsite. Resident #17's MAR dated December 2022 documented the medication was last administered on 12/07/22. A physician's order dated 03/21/22, documented carbamide peroxide solution 6.5 percent, two drops in each ear at bedtime, every Monday and Friday. The medication was not available onsite. Resident #17's MAR dated December 2022 lacked documented evidence the medication had been administered. On 12/08/22 at 3:28 PM, the Medication Technician confirmed the Vitamin B-12 tablets and the carbamide peroxide solution were not available onsite. Resident #18 Resident #18 was admitted to the facility on 10/20/22, with a diagnosis of Alzheimer's Disease. A physician's order dated 10/21/22, documented pravastatin sodium tablet 20 milligrams (mg), give half tablet (10 mg) by mouth, one time a day at bedtime. The medication was not available			

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	onsite. Resident #18's MAR dated December 2022 documented the medication was last administered on 12/06/22. On 12/08/22 at 3:45 PM, the Medication Technician confirmed the pravastatin sodium tablets were not available onsite. Resident #10 Resident #10 was admitted to the facility on 04/30//21 with diagnoses including diabetes, memory loss and stroke. Resident #10's December 2022 MAR and physician order dated 05/28/21, documented -acetaminophen tablet 325 mg, give one tablet by mouth every 12 hours as needed for generalized pain. -bisacodyl tablet delayed release 5 mg, give one tablet by mouth every 24 hours as needed for constipation. Both medications were not on site. On 12/08/22 at 3:14 PM, the Medication Technician confirmed the medications were not on site and verbalized not knowing if the medications had been reordered. The Medication Technician verbalized for a resident who was running out of medication the pharmacy would be contacted five to seven days before the medication was to run out. Resident #22 Resident #22 was admitted to the facility on 06/29/21, with diagnoses including hypokalemia, atrial fibrillation and type II diabetes mellitus with hyperglycemia. Resident #22's MAR documented Ondansetron tablet disintegrating, 4 mg. Give one tablet by mouth four times a day for nausea. A physician order dated 07/20/22, documented Ondansetron tablet disintegrating, 4 mg. Gove one tablet four times per day. The medication on site documented Ondansetron orally disintegrating tablet, 4 mg. Take one tablet by mouth every six hours. On 12/08/22 at 2:56 PM, the Medication Technician confirmed the medication on site did not match the MAR nor physician order for Resident #22 and verbalized the medication onsite should have had a change order sticker adhered to the medication bottle. Resident #12 Resident #12 was admitted to			

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	the facility on 07/21/22, with diagnoses including lung cancer, chronic obstructed pulmonary disease, and glaucoma. Resident #12's December 2022 MAR and physician order dated 07/22/22, documented latanoprost solution 0.005%, instill one drop in both eyes in the evening. The medication was not available on site. The medication was last given on 12/06/22. On 12/08/22 at 2:43 PM, the Medication Technician confirmed the medication was not onsite, was reordered on 12/05/22, and was waiting on the family to pick up. Resident #21 Resident #21 was admitted to the facility on 07/12/21 with diagnoses including anxiety, depression, diabetic neuropathy, and hypertension. Resident #21's December MAR and physician order dated 08/17/21, documented acetaminophen tablet 500 mg, take one tablet by mouth as needed for pain. The medication was not on site. On 12/08/22 at 3:14 PM, the Medication Technician confirmed the medication was not on site and verbalized not knowing if the medication had been reordered. On 12/08/22 at 3:20 PM, the Executive Director verbalized the facility's protocol is to reorder medications when there was seven days remaining of the medication. The facility policy titled "Medication Policies and Procedures," dated October 2018, documented administration of resident medications would be done in a manner which ensures medications are ordered, filled, and refilled in a timely manner to avoid missed doses. Severity: 2 Scope: 1			
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other	0920	1) Medications for residents in apartments #15, #107 and #203 were placed in locked box day of inspection. 2) Any resident who self administers and/or stores medication in their apartment will be provided a locked box/cabinet to secure medications in. 3) Executive Director, Health and Wellness Director or designee will verify resident is provided with locked box/cabinet upon admission or when it is determined resident	12/08/2022

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	unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were stored safely in 3 of 52 resident rooms, with residents who were authorized to self-administer their medications (Room #15, #107, and #203). Findings include: On 12/08/22 at 9:35 AM, the Resident, in Room #15, verbalized having medications stored in a three-drawer plastic container without locks. The resident communicated not locking the resident's door when out of the room and has issue opening the lock on the door. On 12/08/22 at 9:38 AM, the Resident Care Coordinator confirmed the medications were not secured and verbalized a facility plan to replace all resident door locks with single motion locks that lock when the resident leaves their room. On 12/08/22 at 10:16 AM, the Resident, in Room #107, verbalized having medications on the kitchen counter. The resident communicated not locking the door when out of the room. On 12/08/22 at 10:18 AM, the Executive Director confirmed the medications were unsecured. On 12/08/22 at 10:39 AM, the Resident was out of Room #203 and medications were on the kitchen counter. The resident's door was unlocked. On 12/08/22 at 10:40 AM, The Executive Director confirmed the door was unlocked and the medications were not secured. Severity: 2 Scope: 1		may keep medication in apartment. Staff will monitor for compliance daily. 4) Executive Director 5) 12/8/2022 6) Attachment	
0938	Maintenance and Contents of Separate File	0938		01/20/202

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SS= D	- NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an Activities of Daily Living (ADL) Assessment was completed on or prior to admission for 3 of 25 sampled residents (Resident #9, #4, and #18). Findings include: Resident #9 Resident #9 was admitted to the facility on 10/27/21 with diagnoses including hypertension, end stage renal disease, type II diabetes mellitus, hypothyroidism and back pain. Resident #9's clinical record documented an admission ADL assessment dated 11/24/21. Resident #9's record lacked documented evidence of an ADL assessment prior to or upon admission.. On 12/08/22 at 4:00 PM, the Administrator confirmed an ADL Assessment was not completed on or prior to admission for Resident #9 as required. Resident #4 Resident #4 was admitted to the facility on 09/21/22, with diagnoses including Alzheimer's disease, dementia,		1)Residents #9, #4 and #18 have ADL assessments that were completed after physical move-in. The three residents have current ADL assessments in the resident charts at this time. 2) Executive Director, Health and Wellness Director or designee will ensure initial ADL assessments are completed within 30 days prior to physical move in and documentation placed in resident chart. 3) Health and Wellness Director or designee will ensure all necessary documentation and required paperwork are in resident chart at time of physical move in. 4) Executive Director, Health and Wellness Director 5) 01/20/2023	3

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	and hypothyroid. Resident #4's clinical record documented an admission ADL assessment dated 09/22/22. Resident #4's record lacked documented evidence of an ADL assessment prior to or upon admission.. On 12/08/22 at 2:56 PM, the Resident Care Coordinator confirmed Resident #4's admission date was 09/21/22. The Resident Care Coordinator confirmed Resident #4's initial ADL assessment was completed one day late and should have been completed on or before the resident's admission. Resident #18 Resident #18 was admitted to the facility on 10/20/22, with a diagnosis of Alzheimer's Disease. Resident #18's initial ADL assessment was dated 10/26/22 and was completed six days late. On 12/08/22 at 1:23 PM, the Resident Care Coordinator confirmed Resident #18's admission date was 10/20/22. The Resident Care Coordinator confirmed Resident #18's initial ADL assessment was completed late and should have been completed on or before the resident's admission. Severity: 2 Scope: 1			
0994 SS= E	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure dangerous items were secured in the common area of the memory care unit and in 4 of 19 resident rooms (Room #1A, #4A, #6A, and #7B). Findings include: On 12/08/22 at 9:34 AM, a plastic cup containing numerous nonretractable ink pens and sharpened pencils was located on	0994	1) Dangerous items, pens and pencils were removed from memory care resident apartments and common areas at time of inspection. 2) Any dangerous items will be secured in a locked area or removed from Memory Care community. 3) Executive Director, Memory Care Director or designee will inspect Memory Care daily for compliance. 4) Memory Care Director, Executive Director 5) 12/8/2022	12/08/2022

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	a table in room 1A. The pens and pencils were removed by the Sales Director. On 12/08/22 at 9:41 AM, six retractable ink pens were located on a table and a shelf in room 4A. The pens were removed by the Sales Director. On 12/08/22 at 9:53 AM, nine sharpened coloring pencils were located on a table in room 6A. The pencils were removed by the Sales Director. On 12/08/22 at 9:58 AM, a large plastic tub containing several dozen sharpened colored pencils was located on a table in the common area outside room 7. The pencils were removed from the table by the Sales Director. On 12/08/22 at 10:00 AM, a retractable ink pen was located on a dresser on room 7B. The pen was removed by the Sales Director. On 12/08/22 at 10:02 AM, the Sales Director confirmed the pens and pencils located in room 1A, 4A, 6A, 7B, and in the common area outside room 7 should have been removed and secured after each use to ensure resident safety. The facility policy titled, "Safety and Memory Care Environment," dated December 2021, documented the facility would ensure residents were safe from physical hazards including sharp items, and staff would remove and secure hazardous items through daily checks. Severity: 2 Scope: 2			
0999 SS= D	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure toxic items were secured in 2 of 19 resident rooms in the memory care unit (Room #5 and #12B). Findings include: On 12/08/22 at 9:44 AM, the following toxic items were	0999	1. Toxic items were secured in apartments 5 and 12B at time of inspection. 2. All toxic items will be stored in a secured area away from resident access in Memory Care community. 3. Memory Care Director, Executive Director or designee will inspect Memory Care daily for compliance. 4. Memory Care Director, Executive Director 5. 12/8/2022	12/08/2022

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	located on the bathroom counter in room 5 of the memory care unit. -one opened bottle of women's daily multivitamin, 100 count. -one opened 3-ounce bottle of Olay moisturizer. -two opened 3-ounce plastic travel bottles each containing a white substance, unlabeled. -one opened and two unopened 10-ounce bottles of Dove lotion. -one opened and one unopened 16-ounce bottles of Cetaphil lotion. -two opened 11.25-ounce bottles of Softsoap hand soap. -one opened 21.4-ounce bottle of Pantene conditioner. -one opened 23.6-ounce bottle of Pantene shampoo. -one opened 500 milliliter bottle of Listerine Ultra Clean. On 12/08/22 at 9:48 AM, the Sales Director confirmed the potential toxic personal care items found in room 5 should have been removed and secured after using. The Sales Director had the items removed. On 12/08/22 at 10:08 AM, the following toxic items were located on the bathroom counter in room 12B of the memory care unit. -one opened 16-ounce bottle of Vanicream moisturizer. -one opened 2-ounce bottle of Gold Bold lotion. -one opened 11-ounce can of Gillette shaving foam. -one opened 10-ounce can of Barbasol shaving foam. -one opened 2.7-ounce dispenser of Dove Plus Mens Care deodorant. -one opened 5.5-ounce can of Tresemme hair spray. -one opened 6.7-ounce can of Colab dry shampoo. -one opened 28-ounce bottle of Tresemme shampoo. -one opened 28-ounce bottle of Tresemme conditioner. -one opened 16.9-ounce of body wash gel. -one opened 12-ounce bottle of Dove 2-in-1 shampoo and conditioner. -one opened 24-ounce bottle of Dove Sensitive Skin body wash. On 12/08/22 at 10:14 AM, the Sales Director confirmed the potential toxic personal care items found in room 12B should have been removed and secured after using. The Sales Director had the items removed. The facility policy titled, "Memory Care Chemical Safety," dated January 2020, documented the facility strove to maintain a safe environment in the			

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	memory care unit and to minimize the risk of harm from toxic chemicals including personal care items not limited to shampoo, body wash, lotions, hair products, and shaving creams. Severity: 2 Scope: 1			
1540 SS= D	Cultural Competency Training Inspector Comments: Based on personnel file review and interview, the facility failed to ensure all employees received cultural competency training within 30 days of their date of hire for 2 of 10 sampled employees. (Employee #2 and #6). Findings include: On 12/08/22 at 11:18 AM, a review of personnel files, the following employees lacked documented evidence of cultural competency training: - Employee #2 was hired as Life Enrichment Partner with a start date of 11/01/22. - Employee #6 was hired as a Caregiver with a start date of 10/26/22. On 12/08/22 at 11:18 AM, the Business Office Manager confirmed Employees #2 and #6 had not taken an approved cultural competency training course. Severity: 2 Scope: 1	1540	1. Cultural Competency training for employees #2 and #6 has been completed. Initial CC training will be completed within 30 days of hire and Annual training will be completed prior to the expiration date of current certificates for all employees. 2. Executive Director, Business Office Director or designee will coordinate initial and annual Cultural Competency training for all employees to be completed timely. 3. Executive Director, Business Office Director or designee will audit all new employee files within 30 days of hire to verify all required training is completed and will track renewal dates for annual training to verify completion in a timely manner. 4. Business Office Director 5. 12/8/2022	12/08/2022

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1700 SS= D	Annual Assessment of History of Each Resident Inspector Comments: Based on record review and interview, the facility failed to obtain a completed Standard Physician Assessment and Placement Determination for 1 of 25 sampled residents (Resident #17). Findings include: Resident #17 Resident #17 was admitted to the facility on 05/09/19, with a diagnosis of dementia. Resident #17 resided in the memory care unit in room 6A. A Standard Physician Assessment and Evaluation for Placement in a Secured Environment form dated 03/24/22, lacked documented evidence whether placement in a secured environment was required for Resident #17. On 12/08/22 at 1:25 PM, the Resident Care Coordinator confirmed the form had not documented whether a secured environment was required for Resident #17. The Resident Care Coordinator verbalized the form should have documented a secured environment was required as Resident #17 had a diagnosis of dementia and had resided in the memory care unit since admission. Severity: 2 Scope: 1	1700	1) Resident #17 original secured environment form sent to physician to complete. Physician verified secured environment is necessary and updated form. 2) Upon move in or change of condition, Health and Wellness Director or designee will obtain completed paperwork verifying proper placement for each resident. 3) Prior to move in or at each change of condition, Health and Wellness Director or designee will verify all placement paperwork is completed and available in resident chart. 4) Health and Wellness Director, Executive Director 5) 01/20/2023 6) Attachment	01/20/2023